



**Read Each Question Carefully.****Answer Question 8 if you answered NO to Question 2 or YES to Questions 3A or 3B.**

8. If the applicant left before January 1, 2022, enter the date the applicant actually departed. List all dates the applicant was absent from Alaska in 2022 through the date of this application. If the applicant is still absent, leave the end date blank. For each type of absence, write the absence reason code in the space provided and list the dates on separate lines. All absence codes are detailed below. If the applicant had more absences than the number of lines provided below, list on an attachment.

Code (A-R)	Absence Begin Date Month - Day -	Absence End Date Year	Why was the applicant absent?


**Absence Codes**

- A. Accompanied an **eligible Alaska resident** as the resident's spouse or disabled dependent. Complete Question 11.
- B. Enrolled and attended school as a full-time student receiving postsecondary education (beyond grade 12). *Download the Education Verification form at [www.pfd.alaska.gov](http://www.pfd.alaska.gov). See Q for secondary education.*
- C. Served as a member of the U.S. Armed Forces. Attach a copy of the applicant's orders.
- D. Received continuous medical treatment under a physician's care. *Download the Medical Treatment Verification form at [www.pfd.alaska.gov](http://www.pfd.alaska.gov).*
- E. Served as a member of Alaska's congressional delegation or staff.
- F. Served as a volunteer in the federal Peace Corps program. Attach proof.
- G. Trained or competed as a member of the U.S. Olympic team. Attach proof.
- H. As a requirement of employment by the State of Alaska.
- I. Other reasons, including business or vacation. Attach explanation.
- J. Sought employment or was employed for a reason other than B, C, E, H or Q. Attach explanation.
- L. Cared for a parent, spouse, sibling, child, or stepchild with a critical life-threatening illness that required the ill individual to leave Alaska for treatment.
- M. Settled the estate of a deceased parent, spouse, sibling, child, or stepchild.
- N. Provided care for a terminally ill family member. *Download the Physician's Statement for Terminally Ill Care form at [www.pfd.alaska.gov](http://www.pfd.alaska.gov).*
- P. Employed aboard a vessel of the U.S. Merchant Marine.
- Q. Enrolled and attended school as a full-time student receiving secondary education (grades 7 through 12). *Download the Education Verification form at [www.pfd.alaska.gov](http://www.pfd.alaska.gov). See B for postsecondary education.*
- R. Participated for educational purposes in a student fellowship sponsored by the United States Department of Education or by the United States Department of State. Attach Proof.
- S. Permanently relocated outside Alaska.

**Answer Questions 9 and 10 if you answered YES to 3B.**

9. Has the applicant ever lived in Alaska as a resident for at least 180 days? If YES, list the dates of that most recent period before the first absence listed in Question 8. YES ☐ NO ☐

From (Month-Day-Year) Through (Month-Day-Year)

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10. Was the applicant in Alaska for at least 72 consecutive hours during 2021 or 2022? YES ☐ NO ☐  
If YES, when was the applicant most recently in Alaska?  
☐ 2021 ☐ 2022 *Attach documentation showing the applicant was in Alaska.*

**Answer Question 11 if you answered NO to Question 1.**

11. If married, provide spouse information. Your spouse must file a separate application if applying.

First Name M.I. Last Name

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Spouse's Social Security Number

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Spouse's Date of Birth (Month-Day-Year)

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**Answer Questions 12 & 13 if you answered NO to Question 4.**

12. What is your alien registration number and PRC expiration?

A-	EXPIRATION DATE (mm/dd/yyyy)
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13. What was your legal immigration status on December 31, 2021?

☐ Resident ☐ Asylee ☐ COFA  
☐ Refugee ☐ U.S. National (non-naturalized)  
☐ Visa 

VISA TYPE
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EXPIRATION DATE (mm/dd/yyyy)
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If this is the first time you are applying for a dividend, attach a copy of the front and back of your visa or alien registration card.

**Veterans Information**

Note: Providing this information is voluntary. By participating in this program we will release your name, address, branch and dates of service to the Dept. of Military and Veterans Affairs, who will release it to veterans service organizations. These organizations are not required to keep your information confidential.

Service branch? Army ☐ Air Force ☐ Coast Guard ☐ Marines ☐  
 Alaska Territorial Guard ☐ Navy ☐

Dates of service? \_\_\_\_\_

**Alaska Department of Revenue  
Permanent Fund Dividend Division  
Licensed Health Care Provider  
Certification of Disability**

PFD Division Use Only

20230

In order for the Department of Revenue to complete the processing of your 2023 Disabled Permanent Fund Dividend (PFD) application, you must have a licensed health care provider complete the information below. You must sign the release before you give it to your health care provider. Send this completed form **with your application** to the address below.

**Applicant**

Printed Name		Daytime Telephone Number
Social Security Number	Date of Birth	Message Telephone Number
Mailing Address		Email Address
City	State	Zip Code

I was disabled **on March 31, 2023** and I authorize the licensed health care provider listed below to release information regarding my disability to the Alaska Department of Revenue.

Signature of Patient (Applicant)	Date
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For purposes of this statement, "**disabled**" means physically or mentally unable to complete and sign a (Permanent Fund Dividend) application due to a serious emotional disturbance, visual, orthopedic, or other health impairment, or developmental disability that is attributable to intellectual disability, cerebral palsy, epilepsy, autism or other cause. Disabled does not mean incompetent. (AS 43.23.095(2))

This is to certify that the patient (applicant) named above is a patient of mine. I certify that the patient was disabled, as defined above, **on March 31, 2023** and that as a result of the disability the patient was unable to timely file a 2023 Permanent Fund Dividend application by March 31, 2023.

Signature of Licensed Health Care Provider	Date
Printed Name of Licensed Health Care Provider	
Mailing Address of Licensed Health Care Provider	Telephone Number
City, State, Zip Code	
Briefly describe condition of patient on March 31, 2023:	

Send this completed form to: **Alaska Department of Revenue  
Permanent Fund Dividend Division  
PO Box 110462  
Juneau, Alaska 99811-0462**